

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05436

5428

CERTIFICATE OF DEATH

Reg. Dist. No. 63

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Caroline	MARYLAND	STATE Maryland	COUNTY Caroline
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Preston - Rural	LENGTH OF STAY (in this place) 10 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Preston - Rural X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Pleasant Road		STREET ADDRESS (If rural give location) Mt. Pleasant Road	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Carrie	(Middle) Edwards	(Last) Chase	OF DEATH: June 23 1955
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: June 15, 1893
9. AGE last birthday 62 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework		10B. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: No data available	
14. MOTHER'S MAIDEN NAME: No data available		15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unk.) 3 No (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 218-20-4751		17. INFORMANT & ADDRESS: William Terry, Philadelphia, Penna.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary Insufficiency			4 hours
ANTECEDENT CAUSE (B) Proxymal Tachycardia			5 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) Systemic Arteriosclerotic Lesions			10 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None			
19A. DATE OF OPERATION: 0 -		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/8 , 19 44 , to June 23 , 19 55 , that I last saw the deceased alive on June 22 , 19 55 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
SIGNATURE [Signature]		ADDRESS [Signature] M. D. [Signature] DATE SIGNED 6/27/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF June 27, 1955	NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery	LOCATION (City, town, or county) (State) Near Preston, Maryland
DATE REC'D BY LOCAL REGISTRAR 6-27-55	REGISTRAR'S SIGNATURE Cornelia D. Plummer	24. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Md.	ADDRESS

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JUL 1 1967

BUREAU V. S.

5429

CERTIFICATE OF DEATH

Reg. Dist. No.

Leo

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marydel</u>		LENGTH OF STAY (in this place) <u>50 Yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marydel</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67</u>		<u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>		/	
3. NAME OF DECEASED: (First) <u>Edith</u> (Middle) <u>S.</u> (Last) <u>Dailey</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>6</u> <u>13</u> <u>55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>2/1/1887</u>	
9. AGE last birthday: <u>68</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Calvin R. Frazier</u>				14. MOTHER'S MAIDEN NAME: <u>Rachel Steele</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO.: <u>222-16-9706B</u>		17. INFORMANT & ADDRESS: <u>J. Seward Dailey Marydel, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Gallbladder</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>May 10 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of Gallbladder - hectogloss to liver</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1</u> , 19 <u>55</u> , to <u>June 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>55</u> , and that death occurred at <u>10:25</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Freeman</u>		ADDRESS <u>Frederick, Md.</u>		DATE SIGNED <u>June 15, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		LOCATION (City, town, or county) (State) <u>Camden, Delaware</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/16/55</u>		REGISTRAR'S SIGNATURE <u>al Smith</u>		24. FUNERAL DIRECTOR <u>J. E. Boulain</u>		ADDRESS <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5430

05438

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>CAROLINE</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>CAROLINE</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>RURAL RIDGELY</u>		LENGTH OF STAY (In this place) <u>58 yr</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>RURAL RIDGELY</u>		OR TOWN <u>RURAL RIDGELY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>JOHN</u>		(Middle) <u>STOUDT</u>		(Last) <u>EBLING</u>		(Month) (Day) (Year) <u>JUNE 15 1955</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>NOV 14 1888</u>	
9. AGE last birthday: <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		11. BIRTHPLACE (State or foreign country): <u>PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>GABRIEL K EHLING</u>			
14. MOTHER'S MAIDEN NAME: <u>MARY STOUDT</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			
16. SOCIAL SECURITY No.: <u>—</u>				17. INFORMANT & ADDRESS: <u>STATE POLICE</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Crushed Skull</u> DUE TO Antecedent cause(s) (b) <u>Internal Hemorrhage</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Immediate</u> ..	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>05</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street office bldg., etc., INJURY <u>Highway</u>		21c. (City or town) <u>Rural Ridgely</u> (County) <u>Caroline</u> (State) <u>MD</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6 15-53 705A</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lawson George M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6/17/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>G. Vangel Moore & Son</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF: <u>JUNE 18/55</u>		NAME OF CEMETERY OR CREMATORY: <u>RIDGELY</u>		LOCATION (City, town, or county) (State) <u>CAROLINE MD</u>	
DATE REC'D BY LOCAL REG: <u>6/17/55</u>		REGISTRAR'S SIGNATURE: <u>Lawson George</u>		24. FUNERAL DIRECTOR: <u>G. Vangel Moore & Son</u>		ADDRESS	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5431

05439
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
X TOWN <u>Federalsburg - Rural</u>		<u>45 years</u>		TOWN <u>Federalsburg - Rural</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bridgeville Road</u>				STREET ADDRESS (If rural, give location) <u>Bridgeville Road</u>			
3. NAME OF DECEASED: (First) <u>John</u>		(Middle) <u>Edward</u>		(Last) <u>Elrick</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>February 8, 1880</u>		9. AGE last birthday: <u>75</u> yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Canner and Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Wellersburg, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John E. Elrick</u>				14. MOTHER'S MAIDEN NAME: <u>Isabelle Sturtz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u> </u>		17. INFORMANT & ADDRESS: <u>Mrs. W. Randolph Quillen, Federalsburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						Immediate cause (a) <u>Coronary Occlusion</u>	
Antecedent cause(s) (b) <u>Septicemic Malaria</u>						14a	
DISEASES OR CONDITIONS, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u> </u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lawson D. George</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>6/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>June 6, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Hill Crest Cemetery</u>		LOCATION (City, town, or county) (State): <u>Federalsburg, Md.</u>	
DATE REC'D BY LOCAL REG. <u>June 6, 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

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JUN 24 1955

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 62

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>Penn.</i>	COUNTY <i>Phila.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>X TOWN Denton</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <i>Phila., Pa. 75X-3</i>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>3522 Cottman St. ✓</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>WILLIAM</i>	(Middle) <i>THOMAS</i>	(Last) <i>GILL</i>	(Month) <i>JUNE</i> (Day) <i>25</i> (Year) <i>1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify <i>married</i>)	8. DATE OF BIRTH: <i>Nov. 6, 1899</i>
9. AGE last birthday: <i>55</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Books</i>	11. BIRTHPLACE (State or foreign country): <i>Georgia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME: <i>Andrew J. Gill</i>	
14. MOTHER'S MAIDEN NAME: <i>Isabel Campbell</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>Yes 1918</i>	
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mrs. W. T. Gill</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Hemorrhage</i>			<i>Short time</i>
DUE TO			
Antecedent cause(s) (b) <i>Severed artery of heart</i>			<i>2</i>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
<i>0</i>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>At Highway</i>)	21c. (City or town) <i>Denton</i> (County) <i>Caroline</i> (State) <i>Ind</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>6-25-55 7 M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Reversed radial artery at heart</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Danron O. George</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>6/27/55</i> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF <i>June 30, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>One's Chapel</i>	LOCATION (City, town, or county) (State) <i>Woodbury, Georgia</i>
DATE REC'D BY LOCAL REG. <i>6/27/55</i>	REGISTRAR'S SIGNATURE <i>Wm. D. George</i>	24. FUNERAL DIRECTOR <i>J. Boyd Hoover for Denton, Md.</i>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 28 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5433

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 182 6-20-55 et

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 62

05441

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (on this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <i>Denton</i>	<i>Life</i>	TOWN <i>Denton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Norman</i>	(Middle) <i>Isaac</i>	(Last) <i>Harvey</i>	(Month) <i>June</i> (Day) <i>7</i> (Year) <i>1955</i>
(Type or Print)			
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>7/24/1878</i>
			9. AGE last birthday: <i>75</i> yrs.
			IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Farmer</i>	11. BIRTHPLACE (State or foreign country): <i>Hillsboro MD</i>
12. CITIZEN OF WHAT COUNTRY: <i>USA</i>			
13. FATHER'S NAME: <i>John H. Harvey</i>		14. MOTHER'S MAIDEN NAME: <i>Anna Pennington</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>A</i>	
		17. INFORMANT & ADDRESS: <i>Mr. Mary Lou Denton MD</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause (a) DUE TO <i>Myocarditis Chronic</i>			<i>1 yr.</i>
Antecedent cause(s) (b) DUE TO <i>Brucellosis Chronic</i>			<i>2 yr.</i>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>True Tetanus</i>			
19a. DATE OF OPERATION: <i>none</i>		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Donald D. George</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>6/9/55</i>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		M. D. ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>6/10/55</i>	NAME OF CEMETERY OR CREMATORY: <i>Greenmount</i>	LOCATION (City, town, or county) (State): <i>Hillsboro MD</i>
DATE REC'D BY LOCAL REG. <i>6/9/55</i>	REGISTRAR'S SIGNATURE: <i>Mr. D. George</i>	24. FUNERAL DIRECTOR: <i>J. D. Moore & Son</i> ADDRESS: <i>Denton MD</i>	

OPTIONAL FORM NO. 10 (REV. 5-22-64)

BUREAU V. S.

JUN 16 1965

RECEIVED

5434

CERTIFICATE OF DEATH

Reg. Dist. No. 66

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	LENGTH OF STAY (in this place) <u>50 Yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Herbert</u>	(Middle) <u>E.</u>	(Last) <u>Koenemann</u>	(Date) <u>6</u> (Month) <u>3</u> (Day) <u>55</u> (Year) <u>19</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>2/7/1893</u>
9. AGE last birthday <u>62</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Phila., Pa.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Man</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>August Koenemann</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Spidell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) <u>Yes War I</u>		16. SOCIAL SECURITY NO. <u>216-03-9372</u>	
17. INFORMANT & ADDRESS: <u>Irene Koenemann Ridgely, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.			
IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis.</u>		<u>2-3 hrs.</u>	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Tuberculosis - Colae</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 19, 1955</u> , to <u>June 3, 1955</u> , that I last saw the deceased alive on <u>6-3-55</u> , and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. W. Minner</u>		DATE SIGNED <u>6-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/6/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-4-55</u>		REGISTRAR'S SIGNATURE <u>Mary C. Laird</u>	
FUNERAL DIRECTOR <u>J. E. Boulaie</u>		ADDRESS <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5435

CERTIFICATE OF DEATH

05443
Reg. Dist. No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Caroline		MARYLAND		STATE Maryland		COUNTY Caroline	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Federalsburg		LENGTH OF STAY (in this place) 25 years		CITY (If outside corporate limits, write RURAL and give nearest town) Federalsburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Park Avenue				STREET ADDRESS (If rural give location) Park Avenue			
3. NAME OF DECEASED: (First) George (Middle) Edward (Last) Morris				4. DATE (Month) June (Day) 3 (Year) 19 55			
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: March 23, 1892	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): S tationary Boiler Fireman - Mill			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Newport News, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: No data available				14. MOTHER'S MAIDEN NAME: No data available			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.): No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service): 219-07-9871		17. INFORMANT & ADDRESS: Viola Morris, Federalsburg, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Thrombosis						14 days	
ANTECEDENT CAUSE (S) (B) Chronic heart failure						4 mon.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertensive Cardiovascular disease						? years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-10, 1955 to 6-1, 19 55 that I last saw the deceased alive on 6-1, 1955 , and that death occurred at 10:45 pm from the causes and on the date stated above.							
SIGNATURE Robert C. Kingsbury		M. D. Federalsburg, Md.		DATE SIGNED 6-5-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 5, 1955		NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		LOCATION (City, town, or county) (State) Federalsburg, Maryland	
DATE REC'D BY LOCAL REGISTRAR June 5, 1955		REGISTRAR'S SIGNATURE Margaret H. Frampton		24. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Md.		ADDRESS	

BUREAU V. S.

JUN 24 1955

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